IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IRIS K. SAPOVITS,	:	
	:	
Plaintiff,	:	CIVIL ACTION
v.	:	
	:	NO. 01-3628
FORTIS BENEFITS INS. CO.,	:	
	:	
Defendant.	:	

MEMORANDUM

Baylson, J. **December 30, 2002**

In her Complaint, Iris K. Sapovits ("Plaintiff") seeks damages and other relief arising out of the denial of long-term disability insurance benefits by Fortis Benefits Insurance Company ("Defendant") allegedly in violation of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. ("ERISA"). Plaintiff seeks recovery in Count I for enforcement of the Long Term Disability Plan, Count II for breach of fiduciary duty, and Count III for failure to comport with ERISA notice requirements.

Both parties have moved for summary judgment. Oral argument was held on December 12, 2002. For the reasons set forth below, the Court will grant Defendant's Motion for Summary Judgment and deny Plaintiff's Motion for Summary Judgment.

I. Factual and Procedural Background

Plaintiff was employed by Pennco Management, Inc. ("Pennco"). (Compl. ¶ 11.) Plaintiff alleges that, on or about October 25, 1996, Plaintiff's personal physician determined that she was totally disabled and unable to continue her employment by reason of severe bronchial asthma. Id. ¶ 26. Plaintiff stopped working. Plaintiff further alleges that her employment with

Pennco was terminated on November 25, 1996 as a result of her disability. Id. ¶ 27. On January 23, 1997, Plaintiff applied for long-term disability ("LTD") benefits under the Group Long Term Disability Policy (the "Policy"), an employee welfare benefit plan governed by ERISA issued by Defendant to cover active, full-time employees of Pennco. Id. ¶¶ 13, 30. Defendant reviewed Plaintiff's medical records and denied her claim for LTD benefits on April 16, 1997 for failure to meet the definition of "totally disabled." (Mem. Supp. Defendant's Mot. Summ. J. Ex. 25.)[1]

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[1] The Policy provides that a policyholder has a "disability" or is "disabled" if the policyholder, in a particular month, either satisfies the Occupation Test or the Earnings Test. The Policy provides, in pertinent part:

> Occupation Test
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> - during the first 36 months of a *period of disability* (including the *qualifying period*), an *injury*, or sickness, or pregnancy requires that you be under the *regular care and attendance* of a *doctor*, and prevents you from performing at least one of the *material duties* of your regular occupation; and
> - after 36 months of *disability*, an *injury*, sickness, or pregnancy prevents you from performing at least one of the *material duties* of each *gainful occupation* for which your education, training, and experience qualifies you.
>
> Earnings Test
>
> You may be considered *disabled* in any month in which you are actually working, if an *injury*, sickness, or pregnancy, whether past or present, prevents you from earning more than 80% of your *monthly pay* in that month in any occupation for which your education, training, and experience qualifies you. On each anniversary of the date your *disability* started, we will increase by 7.5% the *monthly pay* figure we use to decide whether you are *disabled* under this test. This increase will not affect the amount of benefit we pay.
>
> If your actual earnings during any month are more than 80% of your *monthly pay* (including the 7.5% increase(s)), you will not be considered *disabled* under the Earnings Test during that month. Salary, wages, partnership or proprietary draw, commissions, bonuses, or similar pay, and any other income you receive or are entitled to receive will be included. However, sick pay and salary continuance for periods not at work will not

Plaintiff appealed the denial of her claim, and Defendant affirmed the denial of LTD benefits on September 20, 1997 because Plaintiff did not meet the definition of "disability." Id. Ex. 39. Defendant amended the policy effective November 1, 1997 (the "Policy Amendment") to provide as follows: "[Defendant has] sole discretionary authority to determine eligibility for participation or benefits and to interpret the terms of the Policy. All determinations and interpretations made by [Defendant] are conclusive and binding on all parties." (Mem. Supp. Plaintiff's Mot. Summ. J. Ex. G.)

Plaintiff filed a Praecipe for Writ of Summons and a Writ of Summons in Civil Action against Defendant, Pennco, and the Policy in the Delaware County Court of Common Pleas, and filed her Complaint on July 11, 2001. Defendant removed the action to this Court on July 17, 2001. Plaintiff filed an Amended Complaint on August 13, 2001 and voluntarily dismissed Pennco and the Policy from the action on September 12, 2001.

On October 15, 2001, Defendant sent to Plaintiff's counsel a letter acknowledging receipt of Plaintiff's appeal to Defendant's Appeals Committee. Id. Ex. 45. In the letter, Defendant also advised Plaintiff's counsel that the Appeals Committee was scheduled to review Plaintiff's file on December 4, 2001 and requested any additional supporting information be received prior to the review. Id. On December 19, 2001, Defendant's Disability Claims Appeals Committee

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> be included. Any lump sum payment will be pro-rated, based on the time over which it accrued or the period for which it was paid.
>
> You may still be considered *disabled* according to the Occupation Test, without regard to your level of current earnings, if you meet the requirements of that Test.

(Mem. Supp. Plaintiff's Mot. Summ. J. Ex. E at FOR00015.)

upheld Defendant's previous denial of Plaintiff's claim because it determined that Plaintiff does not meet the definition of "disability." Id. Ex. 47.

On January 16, 2002, Plaintiff's counsel provided Defendant with additional documentation regarding Plaintiff's medical condition. Id. Ex. 48. In a letter dated February 11, 2002, Defendant determined that no new, compelling documentation was submitted to support Plaintiff's disability claim and noted that the Appeals Committee's prior determination remained unchanged. Id. Ex. 50.

Presently before the Court are Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment, which were both filed on October 15, 2002.

II. Legal Standard

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). An issue is "genuine" if the evidence is such that a reasonable jury could return a verdict for the non-moving party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986). A factual dispute is "material" if it might affect the outcome of the case under governing law. Id.

A party seeking summary judgment always bears the initial responsibility for informing the district court of the basis for its motion and identifying those portions of the record that it believes demonstrate the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 322, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986). Where the non-moving party bears the burden of proof on a particular issue at trial, the moving party's initial burden can be met

simply by "pointing out to the district court that there is an absence of evidence to support the non-moving party's case." Id. at 325. After the moving party has met its initial burden, "the adverse party's response, by affidavits or as otherwise provided in this rule, must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). Summary judgment is appropriate if the non-moving party fails to rebut by making a factual showing "sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex, 477 U.S. at 322. Under Rule 56, the Court must view the evidence presented on the motion in the light most favorable to the opposing party. Anderson, 477 U.S. at 255.

III. Discussion

A. Standard of Review

Counts I and II of Plaintiff's action come under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), which provides a federal cause of action for suits to recover benefits under employee benefit plans or to enforce the terms of such plans. Although ERISA does not set forth the standard of review for an action brought under 29 U.S.C. § 1132(a)(1)(B), the Supreme Court has held that "a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Mitchell v. Eastman Kodak Co., 113 F.3d 433, 437 (3d Cir. 1997) (quoting Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989)). If the administrator or fiduciary is given discretionary authority, an "arbitrary and capricious standard" of review applies to the decision of the administrator or fiduciary. Smathers v. Multi-Tool, Inc., 298 F.3d 191, 194 (3d

Cir. 2002).

1. The 1997 Policy Amendment Controls and Defendant's Decision Should Be Reviewed under the Arbitrary and Capricious Standard

Plaintiff argues that the Policy is devoid of clear, specific language granting any type of discretion to Defendant and that the Policy did not contain a reservation of discretion for Defendant until the Policy Amendment was effective on November 1, 1997, which was well after plaintiff's claim for entitlement to benefits arose. (Mem. Supp. Plaintiff's Mot. Summ. J. at 21-24.) As a result, Plaintiff argues that the Court must apply a *de novo* standard of review to Defendant's decision to deny Plaintiff's claim. Id. Defendant argues that because the policy in effect on the date the administrator makes a final determination is the policy that controls, the Policy Amendment controls because the Policy Amendment was in effect when Defendant made its final determinations on December 19, 2001 and February 11, 2002. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 14-18.) Defendant also argues that the Policy contains implied discretionary authority. Id. Defendant, therefore, concludes that the Court must apply an arbitrary and capricious standard of review to Defendant's decision to deny Plaintiff's claim. Id. at 4-14.

The Third Circuit has held that the benefit plan in effect on the date the administrator actually made the benefits determination is the benefit plan that controls in determining whether the benefit plan gives the administrator or fiduciary discretionary authority. Smathers, 298 F.3d at 196. In Smathers, the plaintiff brought an action against his employer and his employer's Health and Welfare Plan seeking payment of medical claims arising out of an automobile accident he was involved in on August 24, 1997. Id. at 192. On February 1, 1998, while the plaintiff's claim was pending but before the administrator made its determination (January 29,

1999), the plaintiff's employer amended its plan to incorporate a provision giving the administrator discretionary authority in making benefits determinations. Id. at 195.

In deciding whether it should look at the plan or the plan amendment to determine the applicable standard of review, the Third Circuit considered the plaintiff's argument that he had a vested right to have his claim review based on the earlier plan, and, therefore, in accordance with the Third Circuit's jurisprudence, that "right" could not be retroactively denied. Id. Noting that it, along with its sister circuits, had spoken of the retroactive denial of "rights" only in a narrow factual setting where the occurrence of an accident or other event resulted in the vesting of coverage or benefits prior to an amendment affecting the person's substantive rights under the plan, the Third Circuit found that this was not the same type of situation in Smathers. Id. The Third Circuit also found that the plan amendment in Smathers did not change the coverage under the plan or substance of the plaintiff's benefits or his entitlement to them; the only change was the scope of the administrator's discretion and authority. Id. As a result, the Third Circuit held that there was no right vested, nor was there any issue of retroactivity, because the administrator's discretionary authority was in place when that discretion was exercized. Id. at 196.

In reaching its holding in Smathers, the Third Circuit also found persuasive the Ninth Circuit's reasoning in Grosz-Salmon v. Paul Reverse Life Ins. Co., 237 F.3d 1154 (9th Cir. 2001). In Grosz-Salmon, which involved similar facts and the same type of plan amendment as Smathers, the Ninth Circuit concluded that the fact that plaintiff "became permanently disabled and filed her disability claim while the first policy was in effect is irrelevant . . . This court must look to the revised plan to determine the appropriate standard of review." Smathers, 298 F.3d at

196 (quoting Grosz-Salmon, 237 F.3d at 1160-61). The Third Circuit, therefore, looked at the plan amendment because the administrator's discretionary authority from the plan amendment was in place when the discretion was exercised, and applied the arbitrary and capricious standard in reviewing the administrator's denial of the plaintiff's medical claims. Id. at 196-97.

The situation in the present case is different from the situations in Smathers and Grosz-Salmon because the Policy Amendment became effective after Defendant's first two denials of Plaintiff's claims. The Court, however, still holds that the Policy Amendment controls because the Policy Amendment was in effect at the time the Defendant's Disability Claims Appeals Committee upheld Defendant's previous denial of Plaintiff's claim.

In reaching this holding, the Court is persuaded by the Third Circuit's finding in Smathers that, because a similar plan amendment did not change the coverage under the plan, or substance of the plaintiff's benefits, or his entitlement to them, there was no retroactive denial of "rights." As a result, the Court finds that the Policy Amendment, which contains an express grant of discretionary authority, controls and the Court reviews Defendant's denial of Plaintiff's claim under the arbitrary and capricious standard.

Under the arbitrary and capricious standard, "a plan administrator's decision will be overturned only if it is clearly not supported by the evidence in the record or the administrator has failed to comply with the procedures required by the plan. A court is not free to substitute its own judgment for that of the defendants in determining eligibility for plan benefits." Smathers, 298 F.3d at 199 (quoting Orvosh v. Program of Group Ins. For Salaried Employees of Volkswagen of Am., Inc., 222 F.3d 123, 129 (3d Cir. 2000)). Furthermore, "whether a claim decision is arbitrary and capricious requires a determination 'whether there was a reasonable

basis for [the administrator's] decision, based upon the facts as known to the administrator at the time the decision was made.'" Id. at 199-200 (quoting Levinson v. Reliance Std. Life Ins. Co., 245 F.3d 1321, 1326 (11th Cir. 2001) (internal quotations omitted)).

2. The Court Applies a Heightened Form of the Arbitrary and Capricious Standard of Review

Plaintiff claims that Defendant has an inherent conflict of interest as administrator of the Policy because Defendant is outside of the employer company and does not have strong incentives to keep employees satisfied by granting meritorious claims. (Mem. Supp. Plaintiff's Mot. Summ. J. at 24-25.) Plaintiff, therefore, argues that the Court should apply a heightened form of the arbitrary and capricious standard, see Pinto v. Reliance Std. Life Ins. Co., 214 F.3d 377 (3d Cir. 2000), in reviewing Defendant's decision to deny Plaintiff's claim. Id. Defendant argues that the Court should not apply a heightened form of the arbitrary and capricious standard because Plaintiff has failed to establish the existence of specific facts to prove Defendant has a conflict of interest. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 18-20.)

In Pinto, the Third Circuit addressed the standard courts should use when reviewing a denial of a request for benefits under an ERISA plan by an insurance company which, pursuant to a contract with an employing company, both determines eligibility for benefits, and pays those benefits out of its own funds. 214 F.3d at 378. In noting that its sister circuits are split over the issue, the Third Circuit stated, "Most hold that the nature of the relationship between the funds, the decision, and the beneficiary invites self-dealing and therefore requires closer scrutiny, but others allow heightened review only if there is independent evidence that the conflict infected a particular benefits denial." Id. at 383-84. The Third Circuit ultimately held that when an

insurance company is both plan administrator and funder, it is generally acting under a conflict of interest that warrants a heightened form of the arbitrary and capricious standard of review. Id. at 387.

The Third Circuit then addressed what the higher standard of review should be, and again turned to the other circuits, where it found three methods of dealing with a conflict: burden shifting, *de novo* review, and the sliding scale. Id. at 390. The Third Circuit adopted the approach of the sliding scale cases, which allows each case to be examined on its facts, and concluded that the intensity of review should increase in proportion to the intensity of the conflict. Id. at 379, 392. In measuring the degree of scrutiny, courts may take into account the following factors: (1) sophistication of the parties, (2) the information accessible to the parties, (3) the exact financial arrangement between the insurer and the company, and (4) the current financial status of the fiduciary. Id. at 392.

In applying the heightened arbitrary and capricious review to the facts in Pinto, the Third Circuit stated that it was deferential, but not absolutely deferential, to the administrator's decision. Id. at 393. Courts, therefore, should "look not only at the result – whether it was supported by reason – but at the process by which the result was received" and scrutiny should be intensified if there are any procedural irregularities in the decision-making process. Id.

In the present case, Defendant admits that it is a claim fiduciary in certain limited respects in its role as the claims administrator of the Policy. (Answer ¶ 8.) Defendant also processes all claims for payment of benefits under the Policy, and makes payment of any benefits that may be due to a beneficiary in accordance with the terms of the Policy. (Policy Amendment; Policy at 14-22.) Therefore, the Court finds that there is a conflict of interest because Defendant is both

the administrator and funder of the Policy. As a result, the Court reviews Defendant's decision to deny Plaintiff's claim for LTD benefits under a heightened form of the arbitrary and capricious standard.

B. Application of the Heightened Arbitrary and Capricious Standard to the Facts

At oral argument, counsel articulated their widely divergent views on how the Court should interpret Pinto. However, both counsel agreed that the Court's review should be based on the record presented in the summary judgment papers, and that there was no basis for a trial. The Court first reviews Defendant's decision to deny Plaintiff's claim for LTD benefits under the arbitrary and capricious standard, which requires a determination of whether there was a reasonable basis for Defendant's decision, based upon the facts as known to Defendant at the time the decision was made. Smathers, 298 F.3d at 199-200. The Court concludes there is a conflict of interest under Pinto and looks to see both if there were any procedural irregularities in the decision-making process, as well as whether the evidence supports Defendant's decision, or whether it violates the heightened arbitrary and capricious standard. Pinto, 214 F.3d at 392-93.

1. Defendant's Arguments

In its Motion for Summary Judgment, Defendant argues that it relied on the observations and opinions of the following doctors, all of whom either examined Plaintiff and/or reviewed her records:

1. Donald D. Peterson, M.D., a pulmonologist who personally examined Plaintiff and evaluated Plaintiff's asthmatic bronchitis upon the request of Robert Weiss, M.D., Plaintiff's

personal physician[2];

2. Robert Brown, M.D., one of Defendant's internal medicine/pulmonary disease specialists;

3. Dr. Benjamin W. Berg, one of Defendant's internal pulmonary specialists;

4. Patricia J. Neubauer, Ph.D., R.N., who conducted a psychological services review for Defendant; and

5. Craig S. Heligman, M.D., who conducted an occupational medicine review for Defendant.

The observations and opinions relied upon by Defendant are as follows:

a. Report of Donald D. Peterson, M.D., dated February 13, 1997, which followed an examination on February 13, 1997 and which is attached as Ex. I to Plaintiff's Motion for Summary Judgment and Ex. 17 to Defendant's Motion for Summary Judgment at FOR00247-FOR00246

i. Plaintiff "has a long history of coughing and wheezing, often triggered by exposure to perfumes, dust, allergens, tobacco smoke, etc.";

ii. Plaintiff "had two previous courses of desensitization therapy without any effect";

iii. Plaintiff "believes she is much worse when under stress associated with her work";

iv. Plaintiff "has been on many of the different medications used to control and treat asthma, including Albuterol orally and by inhalation . . . various steroid inhalers, including Flovent";

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[2] Plaintiff has not characterized Dr. Weiss as a specialist and there is no evidence on the record to support such a characterization.

v. Plaintiff is "in no acute distress";

vi. Plaintiff's "throat is normal";

vii. Plaintiff's "[c]ardiac examination was unremarkable and she had no edema";

viii. Plaintiff's "[o]ffice spirometry showed mild restriction of pulmonary function, probably associated with her weight";

ix. Plaintiff "has asthmatic bronchitis, triggered by a number of factors"

x. "Fortunately [Plaintiff] does not progress to overt wheezing and respiratory distress";

xi. Plaintiff "has not even felt the need to carry an Albuterol inhaler";

xii. Dr. Peterson spoke with Plaintiff about fine tuning her medications and suggested that she carry her Albuterol inhaler for use as needed; and

xiii. Plaintiff "will continue to be somewhat symptomatic" but Dr. Peterson has reassured Plaintiff concerning her overall preservation of her pulmonary function over the last seven years. (Mem. Supp. Defendant's Mot. Summ. J. at 8-9.)

b. Peer Review Report of Robert Brown, M.D., dated April 3, 1997, which is attached as Ex. I to Plaintiff Motion for Summary Judgment and Ex. 21 to Defendant's Motion for Summary Judgment at FOR00264-FOR00262

i. "[N]o evidence has been presented to support the contention that [Plaintiff] is unable to perform her job because of asthma."

ii. Dr. Weiss' notes support the rationale that there was no

objective evidence presented to substantiate the limitations allegedly due to asthma;

iii. Plaintiff does not need pulmonary rehabilitation;

iv. Plaintiff's "asthma management is satisfactory and her asthma has been demonstrated not to be severe";

v. Plaintiff's "current asthma treatment, in particular as outlined by Dr. Peterson, is appropriate";

vi. Plaintiff "had only two exacerbations, neither of which required hospitalization and only one of which required the use of oral steroids";

vii. Plaintiff "tends to be noncompliant with her medications";

viii. "[D]ata presented do not substantiate asthma that is 'exceedingly problematic'"; and

ix. Plaintiff's physicians had not documented "objectively that [Plaintiff]'s work environment worsens her asthma." (Mem. Supp. Defendant's Mot. Summ. J. 9-10.)

c. Peer Review Report of Dr. Benjamin W. Berg dated August 13, 1997, which is attached as Ex. I to Plaintiff Motion for Summary Judgment and Ex. 36 to Defendant's Motion for Summary Judgment at FOR00382-FOR00379

i. Plaintiff "has mild symptoms, but has a documented component of anxiety, which triggers her respiratory symptoms";

ii. Plaintiff "has a pattern of disease over many years which appears to represent a somatoform personality";

iii. Plaintiff "has multiple complaints and anxiety, which have caused her to see medical attention frequently"; and

iv. "The determination of disability based upon a symptom of wheezing and cough that is not further characterized (severity, limitation of specific job requirements, physiologic deficit such as severe airway obstruction) is not adequate . . . this is especially so, since the vast majority of the notes in the record, as outlined by the prior reviewer, document very good asthmatic control. The specialist evaluation also documents good asthma control. On 3/27 she is described as having chest tightness with shortness of breath. The lungs were clear. This is an example of the discrepant findings noted throughout the chart as related to asthma. A precise assessment of the asthmatic condition with physiologic data from PFTs is essential to an accurate disability determination. The cardiac stress test of 4/3/97 reveals no cardiac problems." (Mem. Supp. Defendant's Mot. Summ. J. 14-15.)

d. Psychological Services Review Report of Patricia J. Neubauer, Ph.D., R.N., dated October 5, 2001, which is attached as Ex. I to Plaintiff Motion for Summary Judgment and Ex. 43 to Defendant's Motion for Summary Judgment at FOR00438-FOR00435

i. Plaintiff "likely had either an adjustment disorder to work stress or a mild anxiety disorder" and that she had "worked until something happened at the onset of the claim to lead her and her physician to decide she should quit work";

ii. "There is nothing in the file to suggest that her anxiety worsened or something changed in her environment";

iii. Dr. Weiss did not refer Plaintiff for psychotherapy, he "did not more stridently request that she see a psychiatrist and she did not do so on her own";

iv. "Dr. Weiss did not change her medications or add new medications for anxiety";

v. Plaintiff "was able to stop [taking] Prozac and her symptoms did not change";

vi. Peer review and consulting physicians "all concluded that there was no evidence that the asthma was severe enough to preclude work, and there was no indication of severe anxiety or depression, the combination of the conditions would not preclude work";

vii. "Even though psychological factors impacted her asthma, there was no reason to believe that [Plaintiff] could not continue to work"; and

viii. Plaintiff may have chosen not to continue to work "to decrease her stress but this would seem to be a lifestyle choice rather than dictated by her condition." (Mem. Supp. Defendant's Mot. Summ. J. 17-18.)

e. Occupational Medical Review Report of Craig S. Heligman, M.D., dated October 5, 2001, which is attached as Ex. I to Plaintiff Motion for Summary Judgment and Ex. 44 to Defendant's Motion for Summary Judgment at FOR00433-FOR00431

i. "The available medical information supports the conclusion that [Plaintiff] had the physical capacity to return to work in her occupation"; and

ii. Dr. Heligman noted the referral to Dr. Neubauer with Psychological Services. (Mem. Supp. Defendant's Mot. Summ. J. 18-19.)

2. Plaintiff's Arguments

a. Records of Dr. Weiss (attached as Exhibit I to Plaintiff's Motion for Summary Judgment at FOR00243-FOR00214) support Plaintiff's claim of disability

In her Motion for Summary Judgment, Plaintiff argues that the observations and opinions

of Dr. Weiss, Plaintiff's longtime primary care physician who examined her multiple times, including an examination on October 24, 1998, prove that she is disabled and entitled to LTD benefits:

i. As part of the initial claim forms that were sent to Defendant, Dr. Weiss completed an "Attending Physician's Initial Statement of Disability" in which he diagnosed Plaintiff with bronchial asthma with subjective symptoms of shortness of breath, cough and wheezing and objective symptoms of decreased breath sounds and wheezing. (Mem. Supp. Plaintiff's Mot. Summ. J. Ex. I at FOR00218.) Dr. Weiss classified Plaintiff's level of physical impairment as "Class 5 - Severe limitation; incapable of minimal activity or sedentary work" and Plaintiff's prognosis as "Poor." Id. Ex. I at FOR00217.

ii. Dr. Weiss also provided Defendant with Plaintiff's records dating back to the 1980s, which Plaintiff claims demonstrate that she was on a number of inhalant and oral medications for bronchial asthma. Id. at 6-7. On October 24, 1996, Dr. Weiss noted that Plaintiff was "[c]omplaining of severe aches, chest pain, shortness of breath, postnasal drip. She could not sleep last night because of the discomfort. She also had a spinning feeling in her head . . . . The patient cannot return to work." Id. Ex. I at FOR00250.

iii. On November 5, 1996, Dr. Weiss wrote that Plaintiff was "still having some difficulty with breathing but it is somewhat improved. She has been out of work since I was her last [sic]. She works in a property management business . . . . She is constantly under stress. The area where she works is not clean. The stress and the environment where she is working leads her asthma to be exceedingly problematic . . . . LUNGS: rather clear today." Id. Ex. I at FOR00249.

iv. On December 10, 1996, Dr. Weiss wrote that Plaintiff [has had a flair of her asthma. She is wheezing. She is out of breath. She has some post nasal drip . . . . She has a history of asthma. It has flared up while she is at work over the last few months but now this infection has made things worse . . . . IMPRESSION: Advised her once again to not return to work." Id.

b. Plaintiff Contends Defendant's Denial of Plaintiff's Claim for LTD Benefits was Arbitrary and Capricious

In her Motion for Summary Judgment, Plaintiff argues that Defendant's decision was arbitrary and capricious because: (1) Defendant was simply wrong in stating that Plaintiff's asthma does not require use of an inhaler; (2) Defendant ignored the opinions of independent reviewers it selected who stated that more information was required to evaluate the claim, and relied instead on the contrary opinion of its in-house physician, a director of the company; and (3) Defendant's imposition of a "new, compelling, evidence" standard for Plaintiff's appeal was arbitrary and capricious. (Mem. Supp. Plaintiff's Mot. Summ. J. at 25-28.)

i. Use of an Inhaler

Plaintiff argues that Defendant simply ignored evidence in the medical record in concluding Plaintiff's asthma was not severe because she was not using inhaled medications, in that the record clearly demonstrates that Plaintiff was using multiple inhalant medications. Id. at 25. Plaintiff claims that because Defendant had no evidence to support its determination, Defendant abused its discretion. Id. Defendant counters that after it reviewed the entirety of Dr. Peterson's report, as well as all the other records and information received, including the reports

of Dr. Brown, Dr. Berg, Dr. Heligman, and Dr. Neubauer[3], as well as number other clinical services and internal reviews, it reached the following conclusions:

1. The management of Plaintiff's asthma has been satisfactory;

2. The evidence does not support Plaintiff's claim for disability benefits or that she is unable to do her job because of asthma;

3. When the medical evidence is compared to the physical/non-physical aspects of her sedentary job as submitted by her employer, Plaintiff can perform her occupation; and

4. Based on all the medical and vocational information, Plaintiff's claim did not meet the policy definition of disability as she had the physical capacity to return to work in her own occupation prior to the end of the qualifying period. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 24-25.)

Because the parties rely upon the same evidence in their arguments, i.e., the doctors' reports, this action is appropriate for summary judgment as there are no genuine issues of material fact. Leonardo-Barone v. Fortis Ins. Co., CIV.A.99-6256, 2000 WL 33666891, at *12 (E.D. Pa. Dec. 28, 2000). In its Motion for Summary Judgment, Defendant set forth evidence it relied upon making its decision. See discussion supra Part III. B. Based upon the evidence provided by Defendant, the Court finds that Defendant's decision to deny Plaintiff's claim for LTD benefits was not only based on Dr. Peterson's note that Plaintiff had not been carrying her Albuterol inhaler, but is justified upon reviewing the entire record.

[3] See discussion supra Part III. B. 1.

ii. Summary and Analysis of the Opinions of Independent Reviewers

Plaintiff claims that neither Dr. Brown nor Dr. Berg definitively stated that Plaintiff was not disabled, stating rather that the information they were provided was inadequate to determine whether she was disabled. (Mem. Supp. Plaintiff's Mot. Summ. J. at 26.) Plaintiff further claims that both Dr. Brown and Dr. Berg expressed a clear need for more information to evaluate Plaintiff because both of their reports indicated that either alone, or in combination with her asthma, Plaintiff's evident psychiatric problems could be disabling. Id. Plaintiff, therefore, argues that Defendant ignored the opinions of Dr. Brown and Dr. Berg and relied on the contrary opinion of its in-house physician, Dr. Heligman, in making its decision to deny Plaintiff's claim for LTD benefits because Dr. Brown and Dr. Berg did not definitively state that Plaintiff was not disabled. Id.

With respect to Plaintiff's argument that further psychologic, psychiatric or pulmonary evaluation and testing was necessary, Defendant argues that it is not an insurance company's job to advise an insured that she may have a psychiatric condition. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 29.) Defendant also argues that further pulmonary evaluation and testing, as suggested by Dr. Berg, was not necessary because it is Plaintiff's, not Defendant's, burden to prove disability. Id. at 31. Moreover, Defendant cites to Dr. Heligman's report, which states:

> [T]he information provided was sufficient for the determination of level of ability as it related to the claimant's physical ability to work in her sedentary occupation, even in the absence of data that may have been available through the additional testing.

Id. at 32 (quoting Mem. Supp. Plaintiff's Mot. Summ. J. Ex. I at FOR00432).

In his report, Dr. Brown stated that, in his opinion, "no objective evidence has been

presented to support the contention that [Plaintiff] is unable to perform her job because of asthma. Her psychological problems, however, may be limiting in that regard, but the problems have not been evaluated adequately." (Mem. Supp. Plaintiff's Mot. Summ. J. Ex. I at FOR00264.) It is clear that Dr. Brown concluded that Plaintiff is not disabled. The Court, therefore, rejects Plaintiff's argument that Dr. Brown did not definitively state that Plaintiff was not disabled.

In his report, Dr. Berg notes that Dr. Weiss, Plaintiff's primary physician, stated that he based his determination that Plaintiff was totally disabled on his opinion that Plaintiff "has continued wheezing and cough when under stress, when not stressed, and when exposed to pollution." Id. at FOR00380. Dr. Berg concluded that "[t]he determination of disability based upon a symptom of wheezing and cough that is not further characterized (severity, limitation of specific job requirements, physiologic deficit such as severe airway obstruction) is not adequate." Dr. Berg, therefore, suggested a formal psychological or psychiatric evaluation to develop a constructive approach to the multiple symptoms, which Plaintiff has complained about but has had problems identifying and defining. Id. at FOR00381-FOR00380. Plaintiff's argument that Dr. Berg did not definitively state that Plaintiff was not disabled is only partially correct. Although Dr. Berg rejected the conclusion of Dr. Weiss, he was open to further evaluation to aid in treating Plaintiff, and he did not opine that Plaintiff was disabled.

However, Plaintiff's argument that Defendant ignored the opinions of Dr. Brown and Dr. Berg is baseless. In Defendant's letters dated September 20, 1997 (Mem. Supp. Defendant's Mot. Summ. J. Ex. 39) and December 19, 2001 (Mem. Supp. Defendant's Mot. Summ. J. Ex. 47), Defendant states that it relied on the reports of Dr. Brown and Dr. Berg in finding that

Plaintiff did not meet the definition of disability in the Policy.

In addition, Dr. Heligman also states that he reviewed the reports of Dr. Brown and Dr. Berg in reaching his conclusion that Plaintiff had the physical capability to return to work in her occupation. (Mem. Supp. Plaintiff's Mot. Summ. J. Ex. I at FOR00433-FOR00431.) In his report, Dr. Heligman provided, in relevant part:

> Both Dr. Brown and Dr. Berg arrived at the same conclusion . . . that the claimant's pulmonary condition was stable, of mild severity, and appropriately treated. They both noted that there was evidence in the records that the claimant's symptoms correlated to self reported anxiety and stress issues and that there was evidence of somatoform behavior present . . . . The most significant difference between the opinions expressed by Dr. Berg and Dr. Brown was that Dr. Berg had recommended a detailed and extensive list of further comprehensive testing that could be done to assess the workplace relationship and disability determination with greater precision.

Id. at FOR00433-FOR00432.

Finally, Defendant did conduct further psychological testing. After Plaintiff filed an appeal with Defendant's Disability Claims Appeal Committee, Deb McGlaughlin, an Appeal Specialist, reviewed the entire file and recommended a psychiatric review after concluding that a psychiatric "component appears to be the triggering factor." (Mem. Supp. Defendant's Mot. Summ. J. Ex. 42 at FOR00429.) As a result, Dr. Neubauer completed a psychological services review of Plaintiff's claim and concluded that "there is no reason to believe that [Plaintiff] could not continue to work . . ." (Mem. Supp. Plaintiff's Mot. for Summ. J. Ex. I and Mem. Supp. Defendant's Mot. Summ. J. Ex. 43 at FOR00436.)[4] Plaintiff did not submit an independent psychological report to Defendant.

The Court, therefore, rejects Plaintiff's argument that Defendant ignored the opinions of

[4] See discussion supra Part III. B. I. d.

Dr. Berg and Dr. Brown because they did not definitively state that Plaintiff was not disabled. Their opinions did not conclude Plaintiff was disabled, which is the issue; and, in any event, their opinions were considered in Defendant's final analysis.

iii. Defendant's Letters Denying Plaintiff's LTD Benefits

Defendant initially denied Plaintiff's claim for LTD benefits in a letter dated April 16, 1997 for failure to meet the definition of "totally disability." (Mem. Supp. Defendant's Mot. Summ. J. Ex. 25 at FOR00270.) The April 16, 1997 letter provides, in pertinent part:

> A review of medical information from Dr. Weiss and Dr. Peterson shows mild restriction of pulmonary function. However, it appears that the management of your asthma has been satisfactory and you do not require the use of an inhaler. An independent peer review of your claim was conducted by Dr. Robert Brown. He indicates that there is no objective evidence to support your claim for disability benefits. Based on this information, it appears that you are not limited from performing your regular occupation and LTD benefits must be denied.

Id.

Plaintiff appealed the denial of her claim, and Defendant affirmed the denial of LTD benefits on September 20, 1997 because Plaintiff did not meet the definition of "disability." Id. Ex. 39 at FOR00396. The September 20, 1997 letter provides, in pertinent part:

> We have just completed a review of this claim based on the medical evidence submitted to date which includes medical information from Dr. Weiss and Dr. Peterson . . . . Medical information was received by this office and reviewed by our clinical services department and by two independent physicians, Dr. Robert Brown and Dr. Benjamin Berg. The submitted information indicates that there is no current objective data to certify a disability that would preclude you from performing the occupation of Accounting and Property Manager. When the medical evidence is compared to the physical/nonphysical aspects as submitted by your employer it is our determination that you can perform your occupation. Based on the above stated medical and vocational information we do not consider your claim as meeting the above definition of disability and consequently can not provide benefits.

Id.

Plaintiff then filed an appeal with Defendant's Disability Claims Appeal Committee. After summarizing the findings of Dr. Weiss, Dr. Peterson, Dr. Brown, Dr. Berg, Dr. Heligman, and Dr. Neubauer, Defendant's Disability Claims Appeal Committee "concluded that the previous denial was appropriate" and upheld Defendant's such denial on December 19, 2001. Id. Ex. 47 at FOR00444.

iv. Defendant's February 11, 2002 Letter Regarding Plaintiff's Additional Documentation

Plaintiff claims that Defendant denied Plaintiff's appeal because of her failure to present "new, compelling, evidence" or "new, compelling documentation" even though those terms do not appear in the Policy. (Mem. Supp. Plaintiff's Mot. Summ. J. at 27.) Plaintiff, therefore, argues that Defendant is imposing a requirement that is extrinsic to the Policy, which is, by definition, arbitrary and capricious under the Third Circuit's decision in Epright v. Environmental Resources Mgmt., Inc., 81 F.3d 335 (3d Cir. 1996). Id. Defendant claims that it received further documentation from Plaintiff's attorney on January 21, 2002, attached as Ex. I to Plaintiff's Motion for Summary Judgment at FOR00620-FOR00446, which Defendant had no obligation to review. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 34-35.) In a letter dated February 11, 2002, Defendant stated that, although Polly Galbraith, M.D., one of Defendant's medical directors, reviewed Plaintiff's additional documentation, Defendant "determined that no new, compelling, documentation was submitted that supports disability continuously from 10/24/96, when [Plaintiff] ceased working, to the present. Therefore, the Appeals Committee's prior determination, outlined by [Defendant's] December 19, 2001 letter, remains unchanged." (Mem. Supp. Defendant's Mot. Summ. J. Ex. 50 at FOR00623.)

In Epright, the plaintiff brought an action alleging improper denial of medical benefits in violation of § 502(a) of ERISA. 81 F.3d at 337. In reviewing the employee benefit plan, the Third Circuit noted that only extrinsic evidence may be used to determine an ambiguous terms, but that it is inappropriate to consider such extrinsic evidence when no ambiguity exists. Id. at 339. There was a dispute as to whether the plaintiff was considered a part-time or full-time employee. Although the plaintiff fell within the definition of full-time employee in the employee benefit plan, the defendant argued that the plaintiff was not a full-time employee because he did not fall within the definition of full-time employee in the Employee Handbook. Id. at 338. The Third Circuit found that the definition of full-time employee in the employee benefit plan was unambiguous, and that the defendant's imposition of the "temporary employee" classification, which the defendant used as the basis for denying the plaintiff's medical benefits, was a standard not required by the employee benefit plan. Id. at 342. The Third Circuit, therefore, held that the defendant acted arbitrarily and capriciously by imposing the "temporary employee" classification, which was extrinsic to the plan.

Epright is not relevant to the present case because there is no issue of ambiguity of terms, and Defendant did not rely on an extrinsic standard in denying Plaintiff's claim for LTD benefits. As Defendant stated, Defendant reviewed Plaintiff's additional documents although it was not required to do so. In its review of the additional documentation, which was not required by the Policy, Defendant simply found that there was no compelling documentation to overturn its decision on appeal. Defendant was not imposing a "new, compelling evidence" standard in reaching its determination that Plaintiff's claim for LTD benefits should be denied.

c. Case Law Interpreting Pinto

The cases Plaintiff cited in her brief and at oral argument in support of her claim are not persuasive or controlling. Plaintiff relies on Skretvedt v. DuPont, 268 F.3d 167 (3d Cir. 2001), to support her argument that the Defendant was required to give substantial weight to the medical opinion of Dr. Weiss, Plaintiff's treating physician, unless it could provide contrary evidence. (Mem. Supp. Plaintiff's Mot. Summ. J. at 26-27.) In Skretvedt, the Third Circuit reversed a finding of summary judgment for the defendant because the defendant's decision was unsupported by substantial evidence. Skretvedt, 268 F.3d at 170. Applying the arbitrary and capricious standard, the Third Circuit rejected the defendant's argument that the medical evidence was inconclusive with respect to the severity or permanence of the plaintiff's disability and found that the medical evidence provided clear support that the plaintiff's disability met the eligibility requirements of his benefits plan. Id. at 184. The Court finds that Skretvedt is distinguishable and, thus, not controlling because, in the instant case, even though the heightened form of the arbitrary and capricious standard applies, there is substantial medical evidence supporting Defendant's conclusion that Plaintiff is not "disabled."

Another case Plaintiff relies on is Cohen v. Standard Insurance, 155 F. Supp. 2d 346 (E.D. Pa. 2001), where Judge Newcomer of this Court granted summary judgment in favor of plaintiff, applying a heightened form of the arbitrary capricious standard. Cohen holds that the Court should look not only at the result and whether it was supported by reason, but also at the process by which the result was achieved. Cohen, 155 F. Supp. 2d at 352. Judge Newcomer concluded, under facts not present in this case, that the defendant's conflict played a role in its decision to deny plaintiff's claim, and that the defendant ignored credible contradictory evidence.

Id. at 352-54. Judge Newcomer found that the defendant improperly relied upon the opinion of its non-treating physicians over plaintiff's treating physicians. Id. at 352.

In this case, although Plaintiff's long-term personal physician, Dr. Weiss, did conclude that Plaintiff was disabled, he was the only physician to make that conclusion. Dr. Peterson, to whom Plaintiff was referred by Dr. Weiss himself, never concluded that Plaintiff was disabled after personally examining Plaintiff. It is true that the other physicians on whom Defendant relied did not personally treat the Plaintiff, but their findings and conclusions are supported by and consistent with Dr. Peterson's finding and conclusion.

The Policy does not specify whether Defendant can rely on the opinions of medical professionals who have not seen, spoken with or examined claimants. The Court, however, follows the decision of Judge Weiner in Leonardo-Barone, see discussion infra, and finds that the decision to rely upon a review of the written reports of other physicians does not render the denial arbitrary because, by doing so, Defendant violated no provision of the Policy. See Leonardo-Barone, 2000 WL 33666891, at *13. Some of the physicians who Defendant consulted were pulmonary specialists, whereas Dr. Weiss is Plaintiff's primary care physician. Plaintiff has not characterized Dr. Weiss as a pulmonary specialist and there is no evidence to support such a characterization. Defendant was entitled to give more weight to medical specialists.

Plaintiff also relies on another decision by Judge Newcomer in Holzschuh v. Unum Life Ins. Co., CIV.A.02-1035, 2002 WL 1609983 (E.D. Pa. July 18, 2002), which also found a conflict of interest and applied the heightened form of the arbitrary and capricious standard. In determining how deferential he should be to the defendant's decision, Judge Newcomer concluded that he should view the defendant's decision to deny the plaintiff's claim with

significant skepticism because he found there were procedural anomalies in the defendant's decision making process, such as the defendant's use of non-treating/examining physicians to deny the plaintiff's claim. Holzschuh, 2002 WL 1609983, at *6. Ultimately, Judge Newcomer found that the record revealed that "Unum acted more like plaintiff's adversary than an impartial judge of his claim for benefits" in violation the heightened form of the arbitrary and capricious standard. Id. at *8-9. As discussed above, this Court can make no such conclusion about Defendant's behavior.

Indeed, the Court's conclusions about Defendant are somewhat corroborated in the decision by Judge Weiner in Leonardo-Barone v. Fortis, supra, in which Judge Weiner reviewed Fortis' record and conduct in denying a claim and found that Fortis had met the appropriate standards under ERISA. Indeed, Judge Weiner notes that Fortis, in that case, as in this one, relied on healthcare professionals who had never seen, spoken with or examined the plaintiff, but that such reliance does not render a denial of benefits arbitrary and capricious because, by doing so, Fortis violated no provisions of the policy. Leonardo-Barone, 2000 WL 3366891, at *13. The Court, therefore, rejects Plaintiff's argument that Defendant's decision to rely upon healthcare professionals who only reviewed the written reports of other physicians renders the Defendant's denial arbitrary.

Although a heightened form of the arbitrary and capricious standard applies because of Defendant's conflict of interest, the Court cannot find any procedural irregularities in the decision-making process. The intensity of the scrutiny, therefore, should be moderate and the Court concludes it should be deferential to Defendant's determination. Defendant's decision to deny Plaintiff's claim for LTD benefits was reasonable because Defendant relied on credible

evidence to support its decision. Although it is clear in the medical reports that Plaintiff has symptoms and has suffered illness from time to time, and is not in any way being accused of malingering or falsity, the Court finds that the record supports Defendant's conclusion that the level of Plaintiff's illness did not rise to disability, as that term is defined in the Policy. The Court, therefore, finds Defendant's decision was reasonable and that Defendant did not violate the heightened form of the arbitrary and capricious standard. Thus, the Court will grant Defendant's Motion for Summary Judgment and deny Plaintiff's Motion for Summary Judgment with respect to this issue.

C. Certificate of Insurance

In her Motion for Summary Judgment, Plaintiff also argues that Defendant's Certificate of Insurance fails to contain a significant amount of the information required to be included in the summary plan description ("SPD") in violation of ERISA. (Mem. Supp. Plaintiff's Mot. Summ. J. at 28-29.) Defendant makes several arguments in response to Plaintiff's argument.

Defendant first argues that the Third Circuit held that the distribution of an inaccurate or defective SPD is not actionable under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), in Gridley v. Cleveland Pneumatic Co., 924 F.2d 1310, 1318 (3d Cir. 1991). (Mem. Opp'n Plaintiff's Mot. Summ. J. at 42.) Even if this is true, Defendant provides no evidence to prove that Plaintiff brought her defective SPD claim under § 502(a)(1)(B) of ERISA. Because Plaintiff could have brought a civil action to obtain equitable relief to enforce violations of ERISA under Section 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(1)(B), the Court rejects Defendant's first argument.

Defendant next argues that "appropriate equitable relief" under § 502(a)(3) of ERISA is

unavailable for an allegedly defective SPD in the absence of extraordinary circumstances resulting in prejudice or damage through reliance on the defective SPD. Id. Defendant alleges that because there has been, and can be, no showing of extraordinary circumstances in the instant matter, "appropriate equitable relief" under § 502(a)(3) of ERISA is unavailable. Id.

In Gridley, the Third Circuit held that ERISA reporting or disclosure violations, such as the distribution of an inaccurate summary plan description, cannot provide a basis for equitable estoppel, at least in the absence of "extraordinary circumstances." Gridley, 924 F.2d at 1319 (citation omitted). Because Plaintiff has provided no evidence of extraordinary circumstances resulting in prejudice or damage through reliance on the defective SPD, the Court finds that the allegedly defective SPD did not violate § 502(a)(3) of ERISA.

Defendant's final argument is that it is not liable for violations of § 502(a)(4) and (c) of ERISA, 29 U.S.C. § 1132(a)(4) and (c), due to the allegedly defective SPD because the plan administrator or plan sponsor is the one who is required to furnish a SPD to each participant or beneficiary and it is not the plan administrator or plan sponsor. (Mem. Opp'n Plaintiff's Mot. Summ. J. at 42-43.) Defendant, therefore, claims that it was not required to provide the SPD and, therefore, cannot be subject to penalties for a defect in or failure to disclose the SPD. Id. at 43.

Section 502(a)(4) of ERISA, 29 U.S.C. § 1132(a)(4), allows a participant to bring a civil action for violations of § 105(c) of ERISA, 29 U.S.C. § 1025(c), which provides:

> Individual statement furnished by administrator to participants setting forth information in administrator's Internal Revenue registration statement and notification of forfeitable benefits. Each administrator required to register under section 6057 of the Internal Revenue Code of 1986 [26 U.S.C. § 6057] shall, before the expiration of the time prescribed for such registration, furnish to each

> participant described in subsection (a)(2)(C) of such section, an individual statement setting forth the information with respect to such participant required to be contained in the registration statement required by section 6057(a)(2) of such Code. Such statement shall also include a notice to the participant of any benefits which are forfeitable if the participant dies before a certain date.

29 U.S.C. § 1025(c). Because Plaintiff does not allege a violation of § 105(c) of ERISA, 29 U.S.C. § 1025, the Court need not determine whether Defendant is liable for the allegedly defective SPD under § 502(a)(4) of ERISA, 29 U.S.C. § 1132(a)(4).

Section 502(c) of ERISA, 29 U.S.C. § 1132(c) provides, in pertinent part:

> (1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 606 or section 101(e)(1) [29 U.S.C. § 1166(a)(1) or (4) or § 1021(e)(1)] with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this title to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.
>
> (2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 101(b)(4) [29 U.S.C. § 1021(b)(4)]. For purposes of this paragraph, an annual report that has been rejected under section 104(a)(4) [29 U.S.C. § 1024(a)(4)] for failure to provide material information shall not be treated as having been filed with the Secretary.
>
> (3) Any employer maintaining a plan who fails to meet the notice requirement of section 101(d) [29 U.S.C. § 1021(d)] with respect to any participant or beneficiary or who fails to meet the requirements of section 101(e)(2) [29 U.S.C. § 1021(e)(2)] with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its

discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 101(f)(1) [29 U.S.C. § 1021(f)(1)].

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 101(g) [29 U.S.C. § 1021(g)].

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 104(a)(6) [29 U.S.C. § 1024(a)(4)], the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to $100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1144(c)(8) of the Social Security Act [42 U.S.C. § 1320b-14(c)(8)].

29 U.S.C. § 1132(c). Plaintiff, however, has not alleged violations of 29 U.S.C. § 1166(a)(1), 1166(a)(4), 1021(e)(1), 1021(b)(4), 1024(a)(4), 1021(d), 1021(e)(2), 1021(f)(1) or 1021(g). The Court, therefore, need not determine whether Defendant is liable for the allegedly defective SPD under § 502(c) of ERISA, 29 U.S.C. § 1132(c).

The Court finds that Plaintiff has not successfully pled that Defendant is liable for violations of ERISA due to the allegedly defective SPD, and, therefore, will grant Defendant's Motion for Summary Judgment and deny Plaintiff's Motion for Summary Judgment with respect to this issue.

IV. Conclusion

For the reasons discussed above, the Court will grant Defendant's Motion for Summary Judgment and will deny Plaintiff's Motion for Summary Judgment.

An appropriate Order follows.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IRIS K. SAPOVITS,	:	
	:	
Plaintiff,	:	CIVIL ACTION
v.	:	
	:	NO. 01-3628
FORTIS BENEFITS INS. CO.,	:	
	:	
Defendant.	:	

ORDER

AND NOW, this 30th day of December, 2002, upon consideration of Plaintiff's Motion for Summary Judgment and Defendant's Motion for Summary Judgment, it is hereby ORDERED that Plaintiff's Motion for Summary Judgment is DENIED and Defendant's Motion for Summary Judgment is GRANTED. Judgment is hereby entered in favor of Defendant and against Plaintiff.

BY THE COURT:

_____

MICHAEL M. BAYLSON, U.S.D.J.

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